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Family Planning Digest

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Pharmacists Inactive As Family Planning Leaders

Few grocers would refuse to display their cans of soup, or refuse to sell even the most fattening of candy and cake products to the most obese of their customers. Most pharmacists, however, refuse to display male contraceptives on their shelves (though they express no such reluctance to show female contraceptive products), and a significant number will not sell contraceptives to unmarried minors—although, not surprisingly, almost 100 percent approve heartily of contraceptive sales to married adults. Surveys of a sample of pharmacists in four states—Hawaii, Pennsylvania, Tennessee and Washington—and in Salt Lake City, Utah—show that they overwhelmingly approve the sale of contraceptives to adults, with the favorable responses running from 94 to 97 percent among those queried. In the four states, a majority, although a smaller percentage (63 to 66 percent), also approve sale of contraceptives to unmarried men and women under 20 years of age. Salt Lake's pharmacists, however, were more reluctant to sell to this group, with only one-quarter to two-fifths willing to do so.

Detailed findings are:

- Pharmacists are reluctant to display the condom, but are more willing to display foams, creams and jellies. For example, display of the condom for sale on a self-service counter was reported by only one percent of the pharmacists queried in Hawaii and by only five percent of those queried in Washington. In contrast, as shown in Table 1, display of foams, creams and jellies was reported by 58 percent in Hawaii, 100 percent in Washington and 98 percent in Pennsylvania.
- Certain differences concerning display and sale to minors arose from differences in laws, religious composition or history. In Utah (which has a law forbidding the display of prophylactics in show windows and in public places, as well as a ban on sale of prophylactics to unmarried persons younger than 18), half of the pharmacists queried stated that giving unmarried minors access to contraceptives leads to increased rates of promiscuity and venereal disease. The majority of the pharmacists queried in Salt Lake City (24 were personally interviewed out of 31 approached) are members of the Church of Jesus Christ of Latter Day Saints (Mormons). In Tennessee, a minority of pharmacists had misgivings about the sale of contraceptives to minors; 12.5 percent said that they thought that "young persons should not be allowed to engage in sexual intercourse."

Donald W. Hastings, Assistant Professor of Sociology at the University of Tennessee, who conducted the surveys in Utah and Tennessee, commented that the attitude of the Utah pharmacists, in relation to selling birth control devices to minors, was "inconsistent." This inconsistency, he said, "is a product of the religious beliefs which proscribe premarital sexual intercourse and stress chastity, and the lack of legislative guidelines which

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makes every pharmacist guardian of the community's morals."

● Attitudes of the pharmacists were influenced by their religion, their age, laws and the size of the communities in which the pharmacies were located. For example, of the 16 pharmacists in the state of Washington who reported they did not sell contraceptives, eight were Roman Catholic. In Pennsylvania, 13 of the 15 who did not sell contraceptives were Roman Catholic. Seventy-eight percent of the Washington pharmacists displayed contraceptives; of the Catholic respondents in that state, 70 percent displayed contraceptives.

Asked whether they favor selling contraceptives to unmarried minors, 80 percent of the younger pharmacists (aged 20-29) in Washington replied affirmatively, while only 58 percent of the pharmacists older than 60 years of age did so. In Tennessee, pharmacists younger than 40 were more likely to sell contraceptives to unmarried minor males and unmarried adults than were pharmacists older than 65 years of age.

In larger cities, pharmacists were more favorably inclined to sell contraceptives to unmarried minors. In Tennessee, the survey indicated that pharmacists in communities with fewer than 1,000 in population were less inclined to endorse contraceptive sales to married adults. Pharmacists in Memphis and Chattanooga were more likely to favor sales of contraceptives to unmarried minors than were pharmacists in smaller communities. Nashville pharmacists, however, indicated the greatest opposition to selling contraceptives to unmarried minor men. In Washington, the favorable response to the question concerning contraceptive sales to unmarried minors was 72 percent in cities of more than 100,000 population, while it was 44 percent in towns of fewer than 5,000.

Table 1. Replies of Pharmacists on Contraceptive Sales in Five States

State	*Response to Questionnaire or Interview*		*Percent Approving Sale of Contraceptives*	*Percent Approving Sale of Contraceptives to Unmarried Men and Women < 20*		*Percent Displaying Condom on Counter*	*Percent Displaying Foams, Creams, Jellies*
	Number	*Percent*		*Men*	*Women*		
Hawaii	92	56	94	69	65	1	58
Washington	850	53	98	66*	66*	5	100
Pennsylvania	780	52	97	73*	73*	13	98
Tennessee	805	31	94	74	67	†	†
Utah (Salt Lake City only)	24	77	92	41	25	‡	‡

* No breakdown was given on male and female minors.

† Tennessee's major cities have ordinances forbidding display of contraceptives (Memphis, Knoxville, Nashville, Jackson, Chattanooga).

‡ Utah has a law forbidding display of contraceptives.

The display of contraceptives was influenced by restrictive legislation—as in Utah and Tennessee—but in at least one state it was influenced by lack of information. Thus, one-quarter of the respondents in Hawaii believed it was illegal to display contraceptives; actually, it is legal, since the only restriction against display is against outdoor advertising of contraceptive items. In Tennessee, according to Hastings, Memphis, Chattanooga, Knoxville, Jackson and Nashville have local laws forbidding display of any birth control device, but for the past two years some pharmacists in certain neighborhoods have, in effect, challenged these laws by displaying contraceptives for sale. The pharmacist's decision to display contraceptives depends on the view of the community, he said.

The pharmacist's role as a guide or source of advice appeared to be limited, according to survey findings. In Washington, 68 percent of pharmacists reported that male customers "rarely" sought advice on contraceptives; 21 percent, "often" did so; and 11 percent, "never" did so. Women sought advice even less frequently—71 percent, "rarely," 19 percent, "often," and 10 percent, "never." Pharmacists in Pennsylvania were asked for advice by male customers "rarely" or "never" in 83 percent of the instances, and "rarely" or "never" by women customers in 80 percent of the instances. However, in Hawaii, 30 percent of the pharmacists queried reported they spent more time than they had five years before in discussing contraceptives or recommending different contraceptive methods to their customers.

Does the pharmacist regard himself as a counselor or advisor in the field of contraceptives? No, according to the surveys. Hastings commented that the findings in Tennessee suggest that the pharmacist "casts himself in the role of technician," and that his information to the patron is usually "limited to the cost and effectiveness as per specific device."

Dr. Ronald J. Pion, Professor of Obstetrics and Gynecology at the School of Public Health of the University of Hawaii, who directed the surveys in Hawaii and Washington, noted that pharmacists are "not leading the way in informing and educating the public about family planning." He added that the surveys suggest that the pharmacist "could be, but is not now, an important family planning resource."

Both Dr. Pion and Professor Hastings stressed the importance of obtaining the pharmacist's support in family planning. Dr. Pion urged that pharmacist representatives be invited to serve on the medical committees and boards of local and national family planning agencies. Hastings recommended that pharmacy schools develop courses specifically providing information on available types of contraceptives. He also urged that pharmacists become actively involved with local, state and federal agencies in counseling young people and adults seeking birth control information. He added that the pharmacist's role as counselor, more than his role as dispenser, be emphasized in improving the pharmacist's public image.

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Illegitimacy

Myths about Welfare Births Are Refuted

Are most of the children of mothers on welfare illegitimate? Are most welfare families black? Are most people on welfare able-bodied loafers who don't want to work? The answer to all these question is "no," according to "Welfare Myths vs. Facts," a recent publication of the Social and Rehabilitation Service (SRS) of the Department of Health, Education and Welfare (DHEW).

Data compiled by the SRS show that more than two out of three (68 percent) of the seven million children in welfare families were born in wedlock. The agency points out that while middle- and upper-income families have usually been able to obtain family planning services from private physicians, poor families have not had this opportunity. "Only in the past few years has government made a concerted effort to deliver such services to the poor," according to SRS.

That such family planning services may affect the numbers born out of wedlock is indicated in a report showing a decline in such births to mothers receiving public assistance in New York City. Out-of-wedlock births declined from 17,622 in 1970 to 16,622 in 1971. (Numerous studies document the fact that poor people had many children who were unwanted at the time of conception largely because they had inadequate access to effective birth control methods.)

Most mothers on welfare are white, not black.

Another myth shattered is that welfare families consist of many children, and that more children are conceived just to get additional welfare payments. In fact, the average welfare mother has three children, "Welfare Myths . . ." points out, and the birthrate for such mothers has been declining. Ninety percent of the children in welfare families are two years old or older, and the average family stays on the welfare rolls for two years. Thus, it is obvious that the majority of these children were conceived or born before the family applied for welfare assistance. What is more, a 1969 Aid to Families with Dependent Children (AFDC) study made by DHEW indicates that during a period when welfare payments nationwide were increasing (1967-1969) the average family size of welfare recipients was declining.

These welfare families are hardly living high off the hog. The typical payment for an additional child, according to the SRS, is $35 a month, hardly enough to defray the costs of supporting a child. Moreover, the average welfare payment to a family is low. In all but four states, the welfare payments to an AFDC family have been below the established poverty level of $331 per month for a family of four. (In Mississippi, the average monthly payment has been $55.) In addition, as pointed out by the Commission on Population Growth and the American Future, "most state standards of need are set in such a manner that progressively less is paid for each child, and 20 states have set maximum payments for each family regardless of the number of children."

Still another myth punctured by SRS is that most welfare families are black. In fact, the largest racial group among welfare families, 49 percent, is white. Blacks represent 46 percent, while the remaining five percent consist of American Indians, Orientals and other racial minorities. Just over 14 percent of those who receive help under the AFDC program are of Latin American birth or ancestry. It is also pointed out that most welfare families, black or white, are headed by women, and thus are less able to subsist economically than are families with both parents present.

In a report on illegitimacy in New York City made for New York Assemblyman Andrew Stein, the 5.7 decline in out-of-wedlock births in 1971 was attributed to greater availability of improved contraceptives to the poor and the reform of the state's abortion law.

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Population Commission:

Welcome and Plan for Stabilization Now

The nation should "welcome and plan for population stabilization," first slowing and eventually halting population growth; at the same time it should guide immigration and internal migration so as to ease the problems caused by Americans' rapid metropolitanization.

These were the principal findings of the Commission on Population Growth and the American Future released last March after two years of private meetings, public hearings and examination of more than 100 research papers submitted by experts on economic, environmental, governmental and social problems.

In order to achieve these goals, the Commission called for "a national policy and voluntary program to reduce unwanted fertility, to improve the outcome of pregnancy, and to improve the health of children." The Commission emphasized that measures must also be taken to conserve resources and halt pollution, quite distinct from action related to population growth or distribution.

The 24-member population panel, headed by John D. Rockefeller 3rd, made scores of individual policy and program recommendations, ranging from such specific details as making identity-free statistical tapes of government agency records available to "responsible" research establishments, to such broad items as eliminating all discrimination against women and ethnic minorities. The Commission emphasized that its recommendations, while addressed to population issues, were designed to embody goals "either intrinsically desirable or worthwhile for reasons other than demographic objectives," consistent with "the fundamental values of American life," as well as to be technically, economically and politically feasible.

The panel rejected a "crisis" approach to solving the population problem in this country, at the same time that it decried complacency. It urged gradual attainment of an average two-child family, "in a way which encourages variety and choice rather than uniformity" in patterns of childbearing. Population stabilization could not be reached

quickly, the Commission report pointed out, without social and economic disruption caused by an "accordion-like continuous expansion and contraction" of average family size over the next several decades.

On the other hand, the Commission members could find no possible benefit to the nation or its people to be derived from continued growth beyond that to which we are already committed (at least 50 million more Americans by the end of the century). The Commission's principal recommendations called for:

- payment of the full costs of all fertility-related health services for all Americans,
- elimination of involuntary childbearing through provision of effective access to contraception, voluntary sterilization and safe, legal abortion to all in need,
- increased biomedical research in human reproduction and contraceptive development, and more and better social and behavioral research, statistical reporting and family planning services evaluation,
- increased access to contraceptive and prophylactic services and information for minors,
- more sex education and more education about population, parenthood, nutrition, environment and heredity,
- an end to discrimination against blacks and other minorities in housing, employment and other areas of American life,
- an end to discrimination against women,
- expanded and liberalized child care and adoption programs,
- maintenance of current immigration levels and a "get tough" policy to halt illegal immigration,
- rational guidance of internal migration to metropolitan areas,
- conservation of our resources and environment, and
- organizational changes in government necessary to attain the recommended objectives.

Presidential and Other Reaction

President Nixon formally received the Commission report on May 5, some six weeks after its issuance. He indicated that its conclusion ". . . should be of great value in assisting governments at all levels to formulate policy." He promised that its recommendations would be followed up at the federal level ". . . as we formulate our national growth and population research policies and our agency budgets. . . ." The President withheld comment on the Commission's principal finding that the country should welcome and plan for a policy leading to popu'ation stabilization, but was strongly critical of two Commission recommendations: eased abortion laws and removal of legal restrictions to provision of birth control to minors. The Commission report also came under attack from the National Council of Catholic Bishops and other Catholic groups. The bishops said the report suffered from a "confined view of the inherent value of every person." Other religious and health leaders praised the report. The American Public Health Association called it "an historic milestone in the progress of nations toward coming to grips with the problem of the rapidly growing human population. This report represents the first time that any nation in the world has considered in breadth and depth the impact of population growth and distribution as it affects the quality of life of all its citizens. . . . APHA endorses the report of the Commission, and will continue to work toward a solution of this major health problem." The Planned Parenthood Federation of America declared it "a carefully thought-through, balanced program aimed at improving the quality of life for all Americans, and most particularly for future generations of American children."

Details of some of the Commission recommendations relating specifically to fertility control are described below:

At an estimated $1 billion of additional social cost a year, public and private health mechanisms are urged to pay the full costs of all prenatal, delivery and postpartum services and pediatric care for the first year of life, contraception, voluntary sterilization and safe, legal termination of unwanted pregnancy, and medical treatment of infertility.

Legal inhibitions on access to contraceptive information, services and supplies should be eliminated; instead, laws should be passed affirming the desirability of such access.

Restrictive abortion laws should be repealed, so that unwanted pregnancies may be terminated ". . . on request by duly licensed physicians under conditions of medical safety, . . . with the admonition that abortion not be considered a primary means of fertility control."

Family planning project grants under Title X of the Public Health Service Act should increase to $225 million in FY 1973, and after FY 1975 should reach $400 million a year. Project grant authority under Title V of the Social Security Act should continue at about $30 million annually; and Office of Economic Opportunity family planning programs should continue to be funded at about $21.5 million a year. State and local governments and private contributors are also urged to increase their support for family planning services.

There should be no financial "means test" to limit eligibility for publicly funded family planning programs.

Administrative barriers to voluntary sterilization—such as age, marital status or parity requirements—should be removed; the decision should be solely that of the patient and the physician.

Rewards for nonchildbearing or penalties for childbearing (such as tax incentives or disincentives, bonuses or withdrawal of subsidies) should be rejected as discriminating against the poor and penalizing children. (The Commission also found that there was no truth to the allegation that welfare mothers bear more children in order to increase their monthly payments, and that there is no "evidence that present tax policies and public expenditures promote the birth of additional children in any social class.")

Establishment of a new National Institute of Population Sciences within the National Institutes of Health was urged to carry on expanded biomedical, social and behavioral research. At least $100 million annually in federal funds was projected as needed for basic biomedical research in human reproduction; another $100 million a year (mostly in federal but partially in private funds) was projected as needed for developmental work on fertility control methods; and $50 million annually in federal funds was projected as the need for behavioral and operational research related to population and family planning.

The Commission called for appropriation of the full $93 million authorized for reproductive research under P.L. 91-572 for FY 1973, and urged that this be increased to $150 million by 1975. Increased private support was also urged.

Affirmative laws should be enacted permitting minors to receive contraceptive and prophylactic information on their own request to reduce ". . . unwanted pregnancies and childbearing among the young" and to decrease high rates of illegitimacy, VD and maternal and infant mortality among this group.

High-quality sex education programs should be made available to all youth through the schools, the media and the community.

A Population Education Act should be enacted to assist schools in establishing well-planned population education programs. At least $25 million should be appropriated by the federal government in the next three years in support of population education.

Federal, state and local government bodies are urged to "undertake positive programs to ensure freedom from discrimination based on sex." Ratification of the Equal Rights Amendment to the U.S. Constitution is supported. Schooling for girls and boys should be modified to remove sex and family role stereotypes and encourage varied life choices and life-styles.

Public and private forces should join to encourage child care programs both "to tap the enormous learning potential of preschool children" and give to mothers who wish it the opportunity to work.

Qualified families who wish to adopt children but cannot afford the full cost should be subsidized to do so.

Immigration should be maintained at present levels of about 400,000 a year because of the contributions immigrants have made and continue to make to our society. But these levels should not be increased. Illegal immigration should be halted through more effective law enforcement backed up by tougher federal legislation.

As an alternative to the traditional path of internal migration to the big cities, migration should be encouraged instead to "population growth centers"—middle-sized cities of 50,000-350,000 people with a potential for future growth.

Freedom of choice in residential location should be encouraged by eliminating racial and economic segregation; more housing for lower income groups should be built in the suburbs.

Coordinated programs of education, health and vocational development and job counseling should be offered to blacks and other deprived minorities.

The dependence of local jurisdictions on the property tax should be reduced, and taxes should be raised instead "on the basis of fiscal capacity and distributed on the basis of expenditure needs."

Local governments should be restructured to "reduce overlapping jurisdictions with limited functions and the fragmentation of multi-purpose jurisdictions . . . ."

Water resources should be conserved; pollution emissions should be restricted; fertilizers and pesticides should be limited; wilderness areas should be preserved; threatened animal life should be protected; clean sources of energy (such as nuclear fusion) should be developed; rivers, air and other common property and public facilities should be priced so as to encourage conservation, rather than, as at present, to induce waste and pollution.

Numerous administrative recommendations included: strengthening of Department of Health, Education and Welfare's Office of Population Affairs; establishment of a Department of Community Development with a population component; creation of an Office of Population Growth and Distribution within the Executive Office of the President, and establishment by Congress of a Council of Social Advisors, one of whose main functions should be monitoring of demographic variables.

The Commission urged early action to implement its proposals because the 1970s are probably "critical . . . in the demographic transition . . . involving changes in family life and the role of women, dynamics of the metropolitan process, the depopulation of rural areas, the movement and the needs of disadvantaged minorities, the era of the young adults produced by the baby boom, and the attendant question of what their own fertility will be — baby boom or baby bust."

In addition, the report pointed out, we now find ourselves in a position where we can encourage a desirable trend of apparently reduced fertility. If we delay, it said, we may instead "find ourselves in a position of trying to reverse an undesirable trend."

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Pregnancy Tests

Do-It-Yourself Kit Seized by FDA

A do-it-yourself pregnancy test, called Ova II, is reported to be doing a brisk business in various parts of the United States, although the Food and Drug Administration (FDA) seized 8,100 units of the test kit last May and filed a federal court complaint against the manufacturer on the grounds that Ova II's label and insert contain "false and misleading" statements as to the test's efficacy. The federal agency also maintains that the kit should properly be classified as a new drug requiring FDA approval before release to the general public. The manufacturer did not obtain this prior approval.

Faraday Laboratories of Hillside, New Jersey, distributor of the kit, in its answer to the FDA complaint, denied that Ova II is a drug, as defined under the Food, Drug and Cosmetic Act, and also denied the FDA charge of false and misleading statements. No court hearing date had been set as *Digest* went to press, and out-of-court negotiations between attorneys for the company and the federal agency were under way. Jeffrey Springer, a staff attorney for the FDA, told *Digest* that the FDA "has taken a very strong position here, and the only settlement we would accept is discontinuation of marketing of the kit, submission of a new drug application and destruction of present kits." The FDA action did not halt production or forbid continued sale of Ova II.

Physicians with wide experience in public health express serious reservations about the kit. As Dr. George Langmyhr, Medical Director of Planned Parenthood-World Population, explained to *Digest:*

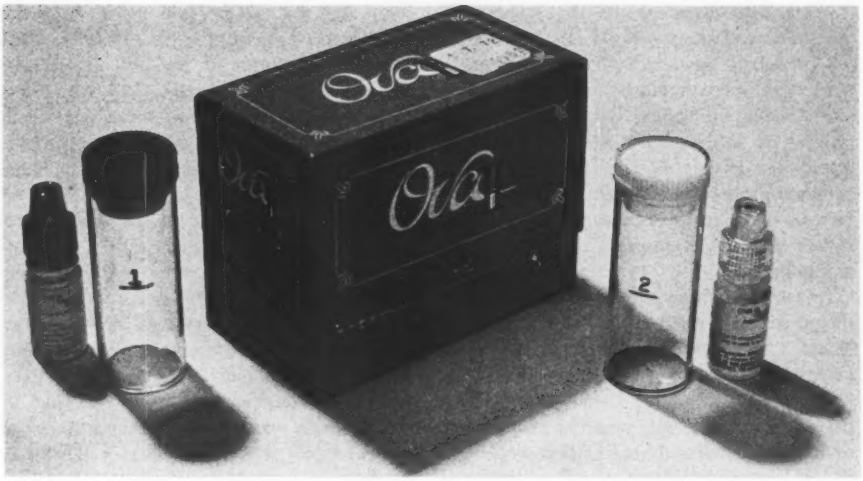
> Obviously the same standard that applies to any medical test should apply to a pregnancy test: It should be safe and as accurate as possible, proven to be so by carefully monitored trials reported upon in responsible scientific journals. Even the best pregnancy tests are not perfect; able researchers report about four percent false positives and eight percent false negatives. We do know that the standard laboratory tests are entirely safe, and this we do not know about any do-it-yourself product.

The birth control agency's medical department alerted its 186 affiliates throughout the nation of the FDA's action on Ova II.

Commenting on the launching of a commercial home pregnancy test in Britain, the *British Medical Journal* observed:

> . . . the fact that a woman knows she might be pregnant implies that she should have medical advice whether the result is positive or negative. She may need advice on contraception if this is not being used or has failed; a decision on possible abortion [may have to be made]; support by the social agencies and possible adoption if an unmarried girl decides to proceed with the pregnancy [may be necessary].

Ova II, described in the distributor's blurb as a "preliminary screening test for pregnancy," comes equipped with two empty tubes, plus one tiny vial containing hydrochloric acid solution, and another tiny vial containing a caustic soda solution. Warnings on the package state: "The solutions in this kit are POISON and can cause severe burns." The test involves mixing urine with the solutions. A package insert states, "This test is for use as a guide only. It can indicate only whether



the urine samples tested contain substances normally present in the urine of pregnant women. The existence or nonexistence of pregnancy must be confirmed by your physician."

The test involves a nine-step process, in which drops from a vial 1.75 inches in height are placed in a two-inch plastic tube, mixed with urine, shaken twice, and then allowed to stand exactly 90 seconds. At the end of 90 seconds, according to the package insert, drops of the solution from the second tiny vial are added to the same tube. A similar process, but with a change in quantities and sequence, is followed in filling a second plastic tube, with urine added, and the shaking is repeated. There is a three-minute wait.

The test is based on color changes in the solutions when mixed with the urine. Results are negative if the color of the mixture in one vial is darker than the color in the other. Results are positive if the colors of the mixture are similar.

The do-it-yourself kit was criticized by Dr. Jean Pakter, Director of the Bureau of Maternity Services and Family Planning of the New York City Department of Health, on the grounds that "it takes experience in technique to differentiate between negative and positive, and this should not be put into the hands of a lay person." She pointed out that in most places a woman can go to a hospital clinic for a pregnancy test, and in many cities Planned Parenthood clinics provide these tests.

A medical opinion favoring safe and accurate home pregnancy testing came from Dr. Ralph W. Gause, Emeritus Professor of Obstetrics and Gynecology at Cornell Medical College, who said that while he was not familiar with Ova II, he felt that it was important that a do-it-yourself home testing kit be developed. "Such a test will not keep the woman away from a physician's office, it will convince her that she should go," Dr. Gause said. He added that the test should be a reliable one, with 95 percent accuracy, and pointed out that the woman, from the very start, would know she was pregnant and behave accordingly.

Arnold Suresky, President of Faraday Laboratories, told *Digest* "many outside laboratories testing Ova II have shown between 92 and 96 percent accuracy," in more than 1,000 tests. He said that the kit went on sale throughout the county last December, and sells for $4.98. He confirmed that no reports of tests of Ova II had appeared in medical journals, but said that data were being assembled for possible submission to a journal.

The most commonly used pregnancy tests today are based on an antigen-antibody action, and none, according to Sylvia Blatt, Assistant Director of the Bureau of Laboratories of the New York City Department of Health, uses such ingredients as solutions of hydrochloric acid or caustic soda. The immunological test is based on the presence of a hormone, human chorionic gonadotropin (HCG), produced by the placenta and found in the urine of a pregnant woman. Two reagents are used. One consists of antiserum to HCG, the other is composed of preserved sheep red cells (or latex particles) coated with HCG. When urine containing HCG is mixed with the antiserum, the HCG uses up all the antiserum and the red cells of the other reagent do not clump. This indicates a positive pregnancy test. The reverse is true if the urine does not contain HCG, since clumping will take place, indicating a negative pregnancy test. The test takes two hours. A rapid slide test, although less accurate, gives results in two minutes.

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AAPPP Roundup—1972

MDs on Birth Control

A new operating technique that may make female sterilization a 15-minute outpatient procedure, a promising animal experiment that holds promise for reversible chemical sterilization of men, continued success rates with a variety of IUDs suitable for never-pregnant women, experience with injectables, a review of the oral contraceptive—all these and more were discussed at the tenth annual meeting of the American Association of Planned Parenthood Physicians (AAPPP) held in Detroit on April 6 and 7. The meeting was attended by more than 300 physicians and other experts active in the delivery of family planning services, contraceptive research, demography and professional education.

Outpatient Female Sterilization Is Found Effective

A new technique of laparoscopic sterilization of women makes it possible to perform the operation on an outpatient basis in about 15 minutes of a hospital stay of less than four hours and at a cost of less than $125, according to Dr. Clifford R. Wheeless, Jr., of the Women's Clinic of the Johns Hopkins Hospital in Baltimore. In addition, the new technique is simple enough for any surgeon to learn quickly, and it has been shown to be much more acceptable to women than traditional techniques because it is associated with minimal scarring, minimal recovery period and minimal exposure to surgery. The objective of outpatient laparoscopic sterilization, said Dr. Wheeless, is to "make female sterilization competitive with vasectomy."

Thus far, Dr. Wheeless explained, he has performed some 2,200 laparoscopic sterilizations on both private and ward patients, three-quarters of them on an outpatient basis.

Operating laparoscope with forceps cutting tube.

(A laparoscope is a thin, stainless steel tube containing bundles of fiber optics which transmit light from an outside source to a lens at the end of the instrument, allowing a surgeon to visualize internal organs. The traditional scope has been modified so that a tiny forceps can be inserted into the tube to carry out an operating procedure. This operating laparoscope is inserted into a two-millimeter incision in the abdominal wall, just below the navel.) Conventional laparoscopic sterilization had been done under general anesthesia, the physician explained, mostly because it required two incisions in the abdominal wall, one for the insertion of the scope, the other for the operating instrument. Attempts to perform the two-step procedure under local anesthesia proved unsatisfactory, with the 100 women on whom it was tried tolerating it "poorly." The modification of the traditional laparoscope, allowing for insertion of the forceps through the scope, led to the development of the one-step procedure that can readily be done under a local anesthetic, the Johns Hopkins professor explained.

Since initiation of this technique, some 500 outpatient sterilizations have been performed at Johns Hopkins, in a rural county clinic in southern Maryland, in the state maternity hospital and overseas in Nepal and El Salvador. Women who are in good health, as established by a previous medical examination, including blood and urine tests, are admitted to the hospital the morning of the operation. After the local anesthetic takes effect, carbon dioxide is injected into the abdominal cavity to expose the fallopian tubes and to separate them from surrounding organs. They are visualized through the scope, a small piece of tissue is removed from each tube and the ends are sealed by electrocoagulation. The gas is then removed and a band-aid placed over the incision. The entire procedure, according to Dr. Wheeless, generally takes about 15 minutes. The women spend between two and three hours in the recovery room and then are discharged to go about their usual business. The physician told *Family Planning Digest* that two-thirds of the women are able to resume their normal activities immediately, although some of them experience the equivalent of menstrual cramps; others apparently need a few days at home for total recovery.

Although the technique represents a great advance over traditional tubal ligation, it is not without some hazard. Dr. Wheeless explained that using "electrocoagulation as a method of sealing . . . the fallopian tubes, we . . . run the risk of inadvertent intra-abdominal and occasional skin burns of the anterior abdominal wall." He said that in two cases (of the 2,200 laparoscopic sterilizations) the terminal ilium had been burned, requiring immediate repair by surgery. In about five cases out of 1,000 the sterilization is not complete (about the same failure rate associated with postpartum tubal ligation).

Dr. Wheeless described the advantages of the one-incision procedure as follows:

- By reducing hospital stay, eliminating the use of the operating room and reducing the amount of time the operation takes, costs are cut sharply — by as much as 90 percent, he estimated.
- The technique is far easier to teach to physicians and far easier to learn. He says that a "practicing obstetrician-gynecologist can generally learn the technique with less than 20 patients," while the two-incision technique requires quite a bit more experience.
- It is tolerated extremely well by the vast majority of women on whom it has been used.

Nonetheless, the physician is not entirely satisfied with the state of the art as it now exists. He feels that a laparoscope should be developed "with the capacity of applying a clip to the fallopian tubes and . . . eliminating the need for . . . electrocoagulation." (Such a device is now under development and has been used on about 20 women, but it is too early to predict its usefulness, according to Dr. Wheeless.) He also noted that there is a need for "miniaturization of the entire package of equipment" which is now so bulky that it cannot be readily transported. He looks forward to the day when a laparoscopic sterilization kit can be packed in an attache case, allowing for its ready use in rural areas here and in developing countries. He said that such miniaturization is also under development, and predicted that such advances would make it possible for the "overwhelming majority" of laparoscopic sterilizations to be performed "in an outpatient clinic facility unassociated with a hospital."

The first such clinic service became available for the first time in the United States when, in June, Planned Parenthood of Syracuse added outpatient laparoscopic sterilization to its comprehensive fertility control services, which now include contraception, vasectomy and pregnancy termination, all on an outpatient basis. The physician performing the procedure, Dr. A. Jefferson Penfield, was trained by Dr. Wheeless.

Hormone Injections May Make Male Temporarily Infertile

Is it possible to interfere with the production of sperm in the testis in such a way that a man would be rendered temporarily infertile? Having accomplished this first step, is it then possible to restore sperm production to normal, rendering him fertile once again? These questions were the basis of a suggestive experiment undertaken by Dr. Alejandro Cervantes, Medical Coordinator of the Asociación Pro-Salud Maternal, in Mexico City.

Dr. Cervantes injected follicle stimulating hormone (FSH), derived from both rats and sheep, into the left testis of 40 normal rats three times a week for five weeks, according to a precise dose schedule. Twenty-four hours after the last injection, the animals were sacrificed with chloroform, the testes were removed, weighed, fixed in solution, and other steps were taken to prepare them for further study. This experiment showed that as early as one week after treatment "a depression of germinal cell development" was noted, and there was an even greater degree of depression after two weeks. On the other hand, at the end of three weeks the untreated testis in each animal had reached what Dr. Cervantes described as "full fertilizing capacity," while the treated testes continued to become further depressed. By the end of the fourth week of FSH administration, after the twelfth injection, the treated testes "were incapable of producing enough mature spermatocytes to insure fertilization," and after the fifth week, the picture was not very different, with some further depression in germinal cell maturation. In the untreated testes, however, full spermatogenesis was reached at the end of the period.

Having established that injection of FSH does, indeed, interfere with the normal development of sperm cells, Dr. Cervantes then attempted to establish whether recuperation occurs and how long the recuperative process takes. This time, a group of 12 21-day-old rats was injected in the left testis with rat-FSH for five weeks, in the same schedule as the previous group. Four groups of three rats each were allowed to recover for periods of one, three, 12 and 20 weeks, respectively, and then were sacrificed at the end of each of these periods for study. In the interim they were placed in separate cages and estrous mature females of the same strain

were made available for mating; 72 hours prior to placing the males with the females their untreated testes were removed.

Although normal sexual behavior was observed, Dr. Cervantes reported, of the first group of three rats sacrificed one week following cessation of treatment, none produced spermatozoa; two weeks following cessation of treatment, two of the three rats in this group produced no spermatozoa, the third produced some which were normal in appearance but nonmotile. The picture of the three rats in the group sacrificed three weeks after cessation was quite different: In these, mature spermatozoa were regularly seen, although "full recovery of the testis . . . [was] still not obtained," according to the physician. Three female rats mated with male rats in this group became pregnant, with the following outcome:

- The litter of one included two offspring, a male born dead and a normal female.
- The litter of the second consisted of two males and five females. One of the two males was normal, the other had an eye infection. Three of the females were normal, but two were born with opacity of the right cornea.
- The litter of the third consisted of two males and three females, all normal. "All the offspring were followed to adulthood," Dr. Cervantes reported, ". . . and their growth and development were apparently normal. When mated, their sexual behavior was normal and in all cases fertility was confirmed by a pregnancy. The offspring of this second generation were also periodically examined . . . [and] sexual maturity was attained at the normal expected time." Twelve weeks following cessation of treatment, the three rats in this group were restored to almost full normality; they were mated, and produced litters in which all the offspring were normal. After 20 weeks full fertility had been restored.

In order to determine if FSH had the same effect in the sexually mature animal, three rats were started at 54 days of age with intratesticular injections which continued for five weeks. They were injected every day for the first week and three times a week thereafter. It was found that only an average of 18 percent of tubules had a fertilizing capacity. Dr. Cervantes summarized his findings as follows:

- The intratesticular administration of FSH caused a specific loss of germinal cells in the immature and the mature normal rat.
- The resultant infertility was reversed within three weeks after discontinuing the treatment.
- Offspring showed no suppression of normal sexual behavior, nor impairment in the development of sexual and somatic characteristics.

"The reversibility of FSH sterilizing effect and its accomplishment with relatively low doses in rats," he concluded, "suggest the possibility of a highly sensitive, specific and nontoxic method, which could be used to inhibit spermatogenesis in humans." Of course, extrapolation from this experience to humans is not warranted, he said, but "these preliminary studies need to be continued over longer periods of time in rats and subsequently in primates."

2nd Generation IUDs Prove Most Effective

Two second generation IUDs—the Copper T (TCu 200) and the Dalkon shield—seem more effective in preventing pregnancy, are expelled less frequently and cause fewer side effects than the best of the older models. But a warning was sounded that success with the IUDs depends heavily on their proper insertion by physicians. When they are incorrectly inserted, as they appeared to be in one clinic, the success rates were considerably lower than those found elsewhere.

A report on the TCu 200 by its developer, Dr. Howard J. Tatum, Associate Director of the Bio-Medical Division of The Population Council, compared the results of 945 insertions of the TCu 200 in 7,740 woman-months of use, with those obtained by 750 insertions of the Lippes loop D in 5,768 woman-months of use, both over a 12-month period. Nine investigators cooperated in this comparative study, eight of them in the United States and one in Canada.

The contraceptive efficacy of the TCu 200 is considerably higher than that of the Lippes loop D, according to Dr. Tatum, with 19 pregnancies reported during 7,740 months of exposure in women wearing the T, compared with 18 pregnancies during 5,768 months in women using the loop. Thus, the number of pregnancies was almost the same although the T had been in use nearly 2,000 months longer. The importance of the clinician in contraceptive efficacy was highlighted when Dr. Tatum explained that "the distribution of pregnancies [by clinics] was not uniformly proportional to the woman-months of use." Eleven, or 58 percent, of the total of 19 pregnancies with the T occurred in one clinic, which had contributed only 13 percent of the total woman-months of use. When the experience in this clinic was excluded from the tabulation, the physician said, "there was a total of eight pregnancies among the remaining 87 percent of the total months of use." The same clinic reported four pregnancies with the loop, or about one-third of the total, although the woman-months of use was less than one-quarter of the total.

Since the experience in this clinic skewed the figures, Dr. Tatum compared net cumulative event rates (pregnancy, expulsion and removal) with the T and the loop, excluding the clinic from the tabulation. He found that the pregnancy rate per hundred women was 0.8 with the T and 2.8 with the loop (or more than three times lower with the T), while the expulsion rate of the T was 6.0 compared with 11.5 with the loop. As in the six-month data, Dr. Tatum explained, the expulsion rate for the T was about half that for the loop. The rate of removal of the two IUDs for bleeding and for pain was 5.4 for the T compared with 9.0 for the loop. The investigator commented: "Although still significantly lower than for loop D, the rate of removal of the . . . T for bleeding and/or pain after one year was greater than had been reported at the end of the first six months." He pointed out that the continuation rate with the T was about 10 percent higher than with the loop.

In conclusion, Dr. Tatum observed that "it is of interest and importance to ascertain the effect that time-in-utero has upon the events associated with an IUD. . . ." To determine this, data on the T and the loop were compiled by quarters over the one-year period. This tabulation showed, he said, that there is a "moderate reduction in the pregnancy rates in succeeding quarters both for the T and the loop D." He postulated that "one of the more likely explanations for this is that the expulsion rates . . . decline with time . . . the highest expulsion rate occurs during the first one to three months." He noted that although there are small differences in the rates for bleeding and/or pain and other medical causes over the four quarters, "it is unlikely that these changes represent significant variations . . . there is no evidence to indicate a diminution in contraceptive effectiveness of the T over the 12-month period."

Dalkon Shield Results Differ

Differences over the efficacy of one device, the Dalkon Shield, were highlighted in two reports, one of them presented by its developer, Dr. Hugh J. Davis, Associate Professor of Gynecology and Obstetrics at the Johns Hopkins School of Medicine, the other by Dr. Mary O. Gabrielson, who had been associated with Planned Parenthood-World Population of Alameda-San Francisco at the time of her study.

Reporting on a three-year experience with 337 nulliparous women fitted by him in his private practice, Dr. Davis found:

- After one year, there were three pregnancies, one expulsion and 19 removals of the shield for medical reasons, yielding a pregnancy rate of 1.1, expulsion rate of 0.3 and medical removal rate of 7.7.
- During the second year of use, there were no additional pregnancies or expulsions, but there were three medical removals, a rate of 3.1.

• During the third year, no additional pregnancies or expulsions were observed, and there was one medical removal.

In addition to the medical removals, 16 shields were removed for personal reasons in the three years under review, Dr. Davis noted. "Excluding removals for personal reasons," Dr. Davis said, "the continuation rate at the end of the first year of use was 91.5 per 100 woman-years . . . at the end of the second year . . . [it] was 89.3 per 100 woman-years."

Dr. Gabrielson reported on 12 and 18 months' experience with some 900 nulliparae, of whom 37 percent were 19 years of age or younger. [For details of 18 months' experience see "Newer IUD's Found Suitable for Nulliparae," *Family Planning Digest*, Vol. 1, No. 3, 1972, p. 9.] The medical removal rate was more than three times higher after the first year than that reported by Dr. Davis: 24.4 compared with 7.1. The pregnancy rate was almost four times higher: 4.3 compared with 1.1. The expulsion rate was 3.4 compared with 0.3. Why these differences?

Dr. Davis pointed out that all his patients were fitted by him in his private practice. The patients in the clinic were fitted by many different physicians. According to Dr. Gabrielson, examination of the records of those who became pregnant "suggested that in at least 25 percent of the cases the shield may not have been correctly inserted." Both physicians agreed that the difference in the medical removal rate may have been due to the fact that, in virtually all instances, Dr. Davis anesthetized his patients by paracervical block while the patients in Dr. Gabrielson's group received no anesthesia. Dr. Gabrielson said it was felt in her group that "paracervical block with its added risk and expense in terms of time and equipment was [not] justified for most of our patients, particularly since the majority of them tolerated the insertion procedure so well."

The difference in pregnancy rates may, at least in part, have been related to Dr. Davis' practice of advising his patients to use an additional contraceptive in the early months following insertion. He advises that foam be used during day 10 to day 17 of the cycle. "The combination of 'calendar foam'," he commented, "plus IUD can therefore be recommended as a means of achieving virtually 100 percent efficacy."

Injectables Prove Acceptable, Effective

Perfect contraceptive efficacy was achieved with three different injectable progestogens when these were administered at the proper interval, reported Dr. Edris Rice-Wray, Director General of the Training and Research Center for Family Planning, Asociación Pro-

Salud Maternal, summarizing experience with 907 Mexican women, the majority of whom live in Mexico City, the rest in a remote rural area. The women were studied during 14,958 cycles of treatment. All the subjects were of proven fertility and free of gynecological or endocrine disease.

The chief difficulty experienced with the injectables, Dr. Rice-Wray explained, was "disorganization of the menstrual cycle, which was characterized by irregular periods of bleeding interspersed with episodes of amenorrhea [absence of menses]." Depending upon the progestogen used, and whether or not it was combined with estrogen, bleeding occurred for from one to seven days in a 30-day cycle to a high of from 11 to 30 days. The days of bleeding were not necessarily consecutive, the investigator noted. These bleeding episodes were interspersed with periods of amenorrhea during which, the physician explained, the women had to be reassured that they were not pregnant. When estrogen was added, the bleeding cycles became more regular and were more often of from one to seven days duration.

The most common side effects were headache, dizziness and nervousness, and the less frequent ones were nausea, menstrual pain and amenorrhea. "The best index of the importance of a given side effect," Dr. Rice-Wray pointed out, "is whether the patient stops the medication because of it." With one of the compounds, 4.7 percent of the patients dropped out because of bleeding, 0.02 percent for nervousness and 0.02 percent for headache during 6,678 cycles of therapy. In another group, the percentages were also low, with 2.7 percent stopping because of bleeding, 0.9 percent for headache and dizziness, and 0.9 percent for headache and nervousness, during 1,377 cycles. In the third group, the percentages were 6.4 percent for headache, 1.8 percent for nervousness and 0.9 percent for bleeding as well as dizziness, during 3,579 cycles. In the rural group, 8.8 percent dropped out for bleeding and 1.5 percent for bleeding and dizziness, during 701 cycles. The investigator concludes that "in spite of the bleeding which appears as a serious problem, very few patients considered it so . . . [and] in spite of the great frequency of amenorrhea . . . a total of only four women stopped because of it."

Although no pregnancies occurred in any patient who received the injections at the proper interval, there were five pregnancies in women taking one compound who received injections from one to six days late. To determine post-treatment fertility "every effort was made to follow up dropouts," Dr. Rice-Wray said. Forty pregnancies were found among those who had discontinued the injectable medication, and these pregnancies occurred after an average of 13 cycles of treatment. The interval from the termination of contraception (determined as the date when a subsequent injection would have been due) to conception ranged from one to 27 months, with an average of three months.

In summarizing her findings on these injectables and those reported in the literature, Dr. Rice-Wray made the following points:

• The drugs are "extraordinarily effective," with 11 authors reporting two pregnancies in 3,818 women during 50,807 cycles of use —a pregnancy rate of 0.047.

● Fertility returns promptly, according to most investigators, but two researchers reported prolonged amenorrhea, suggesting that the injectables should be used not for spacing but for terminating childbearing.
● No abnormalities have been reported in children born to mothers who have used injectables.
● Bleeding, considered by doctors to be the most important disadvantage of the compounds, was acceptable to the majority of the patients. Dr. Rice-Wray emphasized that although the "occasional episode of severe bleeding" is serious, its incidence should be compared "with that of hemorrhage or other complications in repeated pregnancies."

The three injectables used were medroxyprogesterone acetate, given every three months; norethisterone enanthate, given every 84 days; and dihydroxyprogesterone acetophenide with estradiol enanthate, given once a month.

Apparently agreeing with Dr. Rice-Wray that the injectables are a valuable addition to the family of contraceptives now available, the AAPPP passed a resolution urging the FDA to approve one of them, medroxyprogesterone acetate, for marketing in the United States with "appropriate precautionary instructions to the dispensing physician." The resolution noted that although beagles had developed breast nodules after "prolonged administration of very high doses" of the drug, "mammary nodules have not developed in mice, rats, rabbits, and monkeys similarly treated."

Find Orals Remain Acceptable, Useful

In order to determine the true side effects of oral contraceptives with statistical validity, it is necessary to continue to do large collaborative, prospective, carefully controlled long-term studies. At present, however, there is continuing evidence that these agents are highly useful and effective drugs when prescribed responsibly and monitored carefully, Dr. Elizabeth B. Connell, Associate Professor of Obstetrics and Gynecology at Columbia University's College of Physicians and Surgeons, concluded after a review of the literature on the pill. She pointed out that the incidence of side effects "shows great variation," and reminded those present of studies done over the years showing that many of the side effects of the pill are highly subjective in nature. Certain of these studies have shown great similarity between the subjective symptomatology of pill patients and those of women using IUDs and placebos.

Noting the need for pretreatment control data, Dr. Connell reviewed her findings on the effect of the pill on the eye in one such study. It had been reported that the oral contraceptive caused a variety of eye problems, and when Dr. Connell examined her patient population on the pill she found that their eyes did, indeed, appear to deviate from the normal. But was this due to the pill? To find out, the investigator had an ophthalmologist examine the eyes of women who were candidates for the pill, but had not yet begun to use it. She discovered that, prior to treatment, a high percentage of the women had a variety of eye conditions that were not pathological and did not interfere with their vision but certainly were not "normal." The pill was prescribed for these women, who were then monitored meticulously at regular intervals. Dr. Connell found that the preexisting abnormalities were affected not at all by the pill, and no additional abnormalities were detected.

Although there appears to be a well-documented slight increase in thromboembolic morbidity and mortality in women taking the pill, debate is by no means over, she pointed out, on just what the relationship is. The spontaneous incidence of thromboembolism in both men and women was increasing long before widespread use of the pill. Other variables, such as geographic area, climate, smoking and blood type, also appear to play a role. She noted that there is evidence that patients undergoing surgery who have been taking the pill run a slightly increased risk of developing postoperative thromboembolic incidents. It might, therefore, be wise, she suggested, to take women off the pill several weeks or months before elective surgery.

As with thromboembolism, the final results on the pill and cancer are not yet in. There has been no increase in the past several decades in breast or endometrial cancer —two of the most common cancers affecting women—Dr. Connell pointed out, although millions of women throughout the world have taken the pill, some of them for long periods of time. There is even some new evidence from Britain that the pill may exert a protective mechanism against benign breast lesions. An early retrospective study showed an increased association between pills and carcinoma in situ of the cervix. However, more recent studies have pointed out that women who select the pill have a higher incidence of cervical dysplasia even before treatment than those selecting the IUD or diaphragm.

The significance of metabolic studies is also inconclusive, Dr. Connell said. Although the pill appears to affect carbohydrate and lipid metabolism, in some patients, for example, there are no data to show that diabetes or atherosclerosis will be the consequence of these temporary pill-induced changes. She did say, however, that judging from the literature, "a woman with acute or chronic liver disease" probably should not be on the pill.

The situation with respect to lactation is also not entirely clear. The dosage of the pill appears to affect the milk supply proportionately, and so does the timing of the initiation of pill use. Apparently, the sooner the medication is begun following delivery, the greater is the chance of causing a reduction in milk supply. There is some evidence that women who have previously nursed successfully are less apt to have problems.

She made the observation that the incidence of mortality and morbidity associated with pregnancy and delivery are many times higher than that associated with the pill, particularly in areas where medical care is marginal. She discussed the risk-benefit ratio and the fact that many women are unnecessarily frightened away from use of oral contraceptives. She concluded by saying that no radically new contraceptive techniques are around the corner, and that we should continue to use the pill where it is indicated. It must be "considered safe when offered with good medical care."

Sources

Papers presented at the tenth annual meeting of the American Association of Planned Parenthood Physicians, Detroit, Mich., April 6-7, 1972:

A. Cervantes, M.D., "FSH as a Reversible Antispermatogenic Agent in Rats."

E. Connell, M.D., "Current Status and Safety of the Oral Contraceptive."

H. J. Davis, M.D., "The Shield Intrauterine Device: Results in Nulliparous Women."

M. O. Gabrielson, M.D., S. Goldsmith, M.D., and S. Strangeland, "The Dalkon Shield and the Young Nulliparous Patient: Eighteen Months Experience."

E. Rice-Wray, M.D., J. Gutierrez, M.D., J. Gorodovsky, M.D., M. Maqueo, M.D., and J. W.

Goldzieher, M.D., "Injectable Contraceptives in Family Planning—Clinical Experience in 14,958 Cycles."

H. J. Tatum, M.D., "Present Status of Metallic Copper as an Intrauterine Device."

C. R. Wheeless, Jr., M.D., "Outpatient Sterilization by Laparoscopy."

Text of Resolution, passed April 7, 1972.

J. Gorodovsky, M.D., personal communication.

Supreme Court Bars Restrictive Mass. Birth Control Law

A 93-year-old Massachusetts law prohibiting access to birth control by unmarried persons has been ruled unconstitutional by the U.S. Supreme Court. The decision, handed down March 22, held that the law had violated the rights of single persons under the equal protection clause of the Fourteenth Amendment. Four justices (Brennan, Douglas, Marshall and Stewart) joined in the decision and two concurred in its result (White and Blackmun). Only Chief Justice Burger dissented.

The Massachusetts law had prohibited the distribution of contraceptives by anyone except physicians who prescribe such articles for married persons, or registered pharmacists who sell contraceptives prescribed by physicians for married persons. Now the only state which bans the distribution of contraceptives to the unmarried is Wisconsin, and its law would also appear to be unconstitutional as a result of the high court's ruling on the Massachusetts case.

William R. Baird, a birth control advocate of Valley Stream, N.Y., was charged with violating the Massachusetts law in 1967 when he exhibited contraceptives and gave a woman a package of vaginal foam after he delivered a lecture to Boston University students. Baird was tried, convicted and given a three-month sentence.

The Massachusetts Supreme Court set aside Baird's conviction for exhibiting contraceptives, but sustained, by a 4-3 vote, his conviction for distributing the foam. The case then went to a federal district court, which upheld the conviction, and then to the U.S. Court of Appeals for the First Circuit, which reversed it. The state then appealed the case to the U.S. Supreme Court.

The majority opinion, written by Justice Brennan, stated that there could be only three possible rationales for the state to distinguish between the rights of married and unmarried persons to secure contraceptives. These were: discouragement of premarital sexual intercourse, the protection of health and deterring the use of contraceptives as such.

Regarding the first, Justice Brennan held that it would be "plainly unreasonable to assume that Massachusetts has prescribed pregnancy and the birth of an unwanted child as punishment for fornication, which is [only] a misdemeanor [in] Massachusetts . . ." with a maximum penalty of a $30 fine or three months in jail; while violation of the birth control ban was a felony punishable by five years in jail. He also pointed out that the distribution of contraceptives used for preventing disease, rather than pregnancy, is not regulated at all. The claim that denying contraception to unmarried persons protects health by controlling distribution of "potentially harmful articles," he ruled, was not found valid, since the law did not similarly restrict distribution to married persons. "Not all contraceptives are potentially dangerous," the court noted, adding that if the law were a health measure, "it would not only invidiously discriminate against the unmarried, but would also be overbroad with respect to the married. . . ." In addition, other federal and state laws already regulate distribution of harmful drugs. Finally, as to the rationale of deterring use of contraceptives, the Court cited the case of *Griswold v. Connecticut*, in which the Court had ruled the Connecticut law prohibiting contraceptive use unconstitutional because it interfered with the right of marital privacy. Following from the *Griswold* case, a ban on the distribution of contraceptives to the unmarried would be "equally unpermissible." In this connection the Court wrote: "If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."

The Massachusetts law had two specific provisions, one limiting access to contraceptives to married persons and the other specifying who may distribute contraceptives. The Court ruled the first was unconstitutional as a violation of the Fourteenth Amendment.

The majority decision did not specifically declare unconstitutional the second provision of the Massachusetts law, but a concurring opinion written by Justice White and joined by Justice Blackmun, held that this restriction was overbroad in restricting distribution of all contraceptives, rather than the distribution only of those which would be harmful.

Justice White noted that "nothing in the record even suggests that the distribution of vaginal foam should be accompanied by medical advice in order to protect the user's health." The state, he added, acknowledges that the vaginal foam is "widely available without prescription." Justice White pointed out that "nothing has been placed in the record" to indicate the marital status of the woman to whom Baird gave the foam, and that it was not necessary, therefore, to decide on the constitutionality of the law's prohibition against distributing contraceptives to the unmarried.

Justice Douglas, who joined in the majority decision, also filed a concurring opinion, declaring that the case should have been decided on the ground of violation of the free speech provision of the First Amendment.

"First Amendment rights are not limited to verbal expression," he wrote ". . . putting contraceptives on display is certainly an aid to speech and discussion. Handing an article under discussion to a member of the audience is a technique known to all teachers and is commonly used."

Source

Supreme Court of the United States, *Thomas S. Eisenstadt, Sheriff of Suffolk County, Massachusetts, Appellant, v. William R. Baird, on Appeal from the United States Court of Appeals for the First Circuit*, No. 70-71, March 22, 1972.

William Baird, challenging Mass. birth control law, gives foam to Boston U. coeds.

College Students

PPWP, ACHA Sponsor Survey of U.S. College Birth Control Services

"Colleges are castrated institutions which rarely recognize the existence of sex until students force the recognition upon them. Courses, or even lectures, on human sexuality almost always find their way into curricula via student pressure." This was the judgment of Dr. Alan F. Guttmacher, President of Planned Parenthood-World Population (PPWP), as expressed to educators attending the annual meeting of the American College Health Association (ACHA) in Atlanta in April. In order to "enhance" health services for college students, specifically as regards birth control and human sexuality, the physician announced plans to form a national college health advisory committee on student sexuality, composed of representatives from both PPWP and ACHA as well as of students; he also announced joint sponsorship by PPWP and ACHA of a national survey of contraceptive and related services provided by the more than 2,500 colleges in the United States.

"The value . . . of the new survey," Dr. Guttmacher explained, "will not be limited to our organizations, but also will benefit many health institutions, such as state and local health departments." He noted that the projected survey has elicited "much interest from college administrators since it will enable colleges to consider, plan, and develop expanded clinical birth control services with full knowledge of the practice of other colleges in their region as well as the nation."

Dr. Guttmacher said that it appeared that "college youth of both sexes have scuttled and sunk the double standard, and . . . it is rather generally accepted that by the senior year in many colleges, 70 percent of the single students of both sexes are engaging in intercourse." He estimated that at least five percent of unmarried female students, undergraduate and graduate, become pregnant annually. "Since there appears to be no likelihood that the 70 percent figure is going to change in the near future, whether you and I approve of premarital sex or not, don't you think, that colleges should recognize that premarital sex is a reality . . . and create policies and programs accordingly?"

Two promising developments indicating greater concern for the sexual needs of students were cited by Dr. Guttmacher. One is the development of peer counseling groups, now estimated at about 500, compared with only 12 three years ago. Under these programs, several male and female students get about 10 hours of intensive instruction from physicians and faculty members in such disciplines as psychology, biology and sociology, and also read the pertinent literature. They are then available for consultation at certain hours. The second development is production of many student-oriented and student-written pamphlets on human sexuality and particularly on contraception. [For a review of such literature see "Student Printing Presses Bring Birth Control Story to Colleges," *Family Planning Perspectives*, Vol. 4, No. 1, 1972, p. 60.]

In relation to the latter development, a pamphlet, "What You Should Know About Contraception," produced and distributed by the ACHA to college health services throughout the country, has already gone beyond the 52,000 mark in sales. The pamphlet was introduced last summer, along with one on mononucleosis and another on colds. Of the three, the birth control pamphlet is the top seller.

The pamphlet on birth control describes various contraceptive methods, explains the reproductive process and also discusses voluntary sterilization and pregnancy termination. ACHA officials said that the only promotion for the pamphlet consisted of sending sample copies to 575 member institutions. Orders then began to climb.

The ACHA conducted surveys in 1966 and 1970 of contraceptive practices and policies of college health services. Between 1966 and 1970 there was a marked increase in the provision of birth control services for college students. The first survey showed that only four percent of those ACHA members replying (13 institutions) indicated that they were prescribing oral contraceptives for unmarried students who had reached their majority. The 1970 survey revealed that more than 118 institutions, 42 percent of responding ACHA members, were providing this service for the same group.

In addition, 97 colleges in 1970, as compared with 12 in 1966, reported that their health services were willing to prescribe for unmarried minors. Medical contraceptive services for married students also increased, rising from 45 percent to 54 percent of respondents. Citing these figures, Dr. Philip M. Sarrel, Assistant Professor of Obstetrics at the Yale University School of Medicine, noted that a large number of sexually active, unmarried college students were still not receiving contraceptive information and assistance from college health programs.

The importance of providing sound family planning services to college students was highlighted by a University of Massachusetts study of pregnant coeds reported at the ACHA meeting by Lawrence B. Siddall and Michael A. Cann. In 1969-1970, 304 undergraduates were diagnosed as pregnant by the college health service. Physicians were asked to complete questionnaires on each pregnant student, eliciting information about sexual behavior, contraceptive practice and resolution of pregnancy. The physicians completed 137 questionnaires, representing 45 percent of the 304 pregnant students. In addition, 78 of the pregnant students, chosen

at random, were asked to complete similar questionnaires. Forty-two of them did so.

The responses from both sets of questionnaires indicated:

- Although more than half the respondents were already involved in "well-established patterns of sexual intercourse," the students' responses indicated that only nine of the 42 girls always used some method of contraception, seven never used any method, 25 sometimes practiced contraception and the practice of one girl was not known.

Of the 34 coeds who had used birth control at some time, most had tried the least effective methods—rhythm and withdrawal; few had ever tried the most effective methods. Experimentation with the various methods was the rule. Twenty-one girls reported that they had tried rhythm; the same number had attempted to use withdrawal. Twelve had relied at some time upon their partners to use the condom. Only three had tried the pill, one, the diaphragm and one, foam. None had used the IUD.

- Asked to explain why contraceptives were not used or why they thought their method failed, many admitted they took a chance because they thought pregnancy "just couldn't happen to them." Several relied on rhythm feeling that no artificial contraception was necessary. Some said they were poorly informed and were "afraid" to ask about contraceptives. Some said they feared the pill or disliked mechanical devices. Others said they relied on the man to provide protection.
- About four percent of the students had been pregnant previously.
- Sixty-nine percent of the pregnancies were terminated by abortion; 23 percent of the pregnant girls married; two percent gave up their babies for adoption and another two percent kept them.

The researchers found that there was little difference in the pregnancy rate between upperclassmen and freshmen and sophomores.

They concluded that "while in a few cases pregnancy may be the result of underlying emotional disturbance, more often it seems to be related to misplaced idealism regarding sexual relationships, the wish for personal closeness, a misunderstanding of contraceptive methods, and the resistance to using mechanical contraceptive devices."

In recognition of the "growing demand for family planning services by students in the colleges and universities of the United States," the Council on Population of the American Public Health Association (APHA) has proposed that the APHA recommend that college health services "offer confidential medical consultation and service on birth control methods, on the diagnosis of pregnancy, and on the diagnosis and treatment of venereal disease."

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Abortion

Health, Social Impact Of Legalized Abortion

Reports from New York and California provide the first assessment of the health and social impact of legalized abortion. Among the consequences reported are reduced septic abortion, reduced maternal mortality and a drop in the number of out-of-wedlock births. Moreover, the longer legalized or liberalized abortion is available, the greater the proportion of women applying for abortion early in pregnancy, with a resultant reduction in the frequency of the relatively higher-risk procedures required for late abortion.

In New York City, where an estimated 278,122 abortions were performed during the first 18 months of legalization—approximately 65 percent of them on nonresidents, the rest on residents—some of the consequential trends reported by Health Services Administrator Gordon Chase were the following:

- In 1971, the maternal mortality rate, inclusive of abortion-related deaths, declined to an all-time low of 2.9 deaths per 10,000 live births compared to 5.3 in 1969, the year before legal abortions became available, and 4.6 the following year. The low 1971 rate, said Mr. Chase, represents an acceleration of a five-year decline in the maternal mortality rate, the latter attributable at least in part to a "greater availability of family planning services."
- The infant mortality rate had also reached a new low, from 24.4 deaths per 1,000 live births in 1969, to 21.6 in 1970 and to 20.7 in 1971. Legal abortion, the report notes, gives women whose infants have the greatest risk of dying—very young women, unwed mothers who generally receive poor prenatal care, women with many previous pregnancies and women with medical problems—options concerning pregnancy termination.
- Based on data through last August, 1971 will be the first year to show a decline in the number of out-of-wedlock births in New York since 1954. (Such births had been increasing steadily.) "For the first eight months of 1970, before the law was passed and before it could have had an impact on women already pregnant," Mr. Chase explained, "there were 20,820 out-of-wedlock births. The number declined to 18,970 for the same period in 1971, when the law was in effect—a decline of 8.9 percent." This was a greater decline than the drop in legitimate births in the same period. For the entire year of 1971, the decline in out-of-wedlock births was 12.5 percent, from 31,900 to 28,100.
- Incomplete abortions also seem to be declining, according to Mr. Chase. In 10 municipal hospitals, incomplete and spontaneous abortions averaged 480 a month for the period July-December 1970, went down to 350 a month for the January-June 1971 period and then dropped to 199 a month for July-December 1971. "It is assumed," the report notes, "that the drop is the result of fewer criminal abortions, since the number of spontaneous abortions is likely to remain relatively steady."
- The complication rate associated with legal abortion has been "steadily improving" over time, the figures show. In the first six months following repeal of the restrictive law, July-December 1970, the complication rate was 12.4 per 1,000. This was reduced sharply during the next six-month period, January-June 1971, to 6.4 per 1,000, and the decline continued, reaching 5.7 per 1,000 abortions between July-December 1971, the lowest for any six-month period so far. The decline occurred for both first trimester abortions and for later abortions, according to the report. The first trimester complication rate went from 7.5 per 1,000 during the first six months following passage of the law to 2.8 per 1,000 for the July-December 1971 period. The complication rate for late abortions dropped from 29.9 to 19.3 for the same periods. "Abortions for all periods of gestation are becoming steadily safer," observed Mr. Chase, "but early abortions are still far safer than later ones. . . ."
- The proportion of first trimester abortions has grown steadily. During the three-month period after the law was passed, 68.6 percent were early abortions; during the three-month period July-September 1971, just under 80 percent were first-trimester abortions. Mr. Chase attributed the improvement to the city's educational campaign urging early abortions.
- Death rates associated with legal abortion have declined over time. "Between July and December 1971, four deaths occurred in New York City associated with abortions

under legal auspices," the record shows, "out of 109,372 abortions . . . [for] a death rate [of] 3.7 per 100,000 abortions. This is down from the rate of 4.7 during the first year of the law. . . ."

Unlike New York State, which effectively legalized abortion as of July 1, 1970, California has a liberalized law which permits legal abortion of pregnancies resulting from rape and incest, and of pregnancies which may lead to serious impairment of the mother's physical or mental health. Passed in 1967, this law has been interpreted more liberally in some parts of the state than others, and especially broadly in the Bay Area around San Francisco. In 1967, the last full year before the new law took effect, there were 518 therapeutic abortions in the entire state, compared to 5,030 in 1968, 15,339 in 1969, 62,700 in 1970 and an estimated 116,000 in 1971. In a report to the ninety-ninth annual meeting in Minneapolis of the American Public Health Association last October, Drs. Phillip J. Goldstein and Gary K. Stewart of San Francisco General Hospital showed a direct correlation between the rising frequency of legal abortion in the state and at San Francisco General, and the sharp drop in septic abortions seen at that hospital. In addition to this drop, (from 68 per 1,000 live births in 1967 to 22 per 1,000 live births in 1969) there was also a drop in "so-called spontaneous abortions" from 125 per 1,000 live births in 1967 to 49 per 1,000 live births in 1969. These figures, they observed, indicated clearly that "there has been a fall in criminal abortions. . . ."

Drop in Maternal Deaths

The drop in septic abortions, they reported, was reflected in the figures on maternal death related to abortion, which went from eight per 100,000 live births statewide in 1967 to just over three per 100,000 live births in 1969, paralleling the New York City experience. The legal abortion death rate, they noted in a recent letter to *Obstetrics and Gynecology*, is far lower than the maternal death rate, making legal abortion safer than continued pregnancy in California at the present time.

Another parallel with New York reported by Drs. Goldstein and Stewart was a trend toward abortion earlier in pregnancy. Here their figures showed an increase in early abortion from 63 percent of the total in 1968 to 74 percent in 1970. Since their own experience at San Francisco General showed a far higher complication rate with late abortions, the two California physicians were extremely critical of any factors that tended to delay an abortion.

Particularly "ridiculous," they felt, was the involvement of psychiatry in the abortion process. The California law, like many of the liberalized abortion laws, requires psychiatric consultation as a condition for performance of the procedure. They said:

> To . . . humiliate a patient by suggestions that she see a psychiatrist, thereby implying that she is unbalanced in seeking an abortion, is doubly obstructing in that she may delay seeking help knowing of this legal provision but may also experience some delays in obtaining an appointment and having the information put in the chart.

This position, stated so forcefully by the two San Francisco obstetricians, is concurred in by many psychiatrists. For example, Dr. Zigmond M. Lebensohn, Clinical Professor of Psychiatry at Georgetown University School of Medicine, told a meeting of the American Psychological Association that abortion is truly therapeutic for most women, and that the excessive safeguards, including psychiatric consultations, required in many states, place a tremendous and unnecessary strain on the patients. He called it a "supreme irony":

> . . . that almost all therapeutic abortions are performed on psychiatric grounds because of anxiety and depression; yet the present system almost seems designed to increase the anxiety and depression of the woman in the critical weeks of waiting for consultations, committee approval, and an available hospital bed. Sometimes the delay is so great and the pregnancy has become so advanced that a simple suction evacuation is no longer possible and a more hazardous and more expensive method must be substituted. The humiliation and frustration experienced by most women in these circumstances . . . cannot be overestimated.

While the depression, anxiety, anguish and despair of women caught in the midst of an unwanted pregnancy "clearly constitute sufficient grounds to recommend therapeutic abortion for the preservation of the mother's mental health," Dr. Lebensohn continued, "such a determination hardly requires the time, expense or expertise of a psychiatrist." On the other hand, he said, if the attending physician feels that his particular patient would benefit from seeing a psychiatrist, he should of course call one in.

Psychiatrists can make a significant contribution in the abortion field, the Georgetown physician suggested, through research into the psychological basis of individual attitudes towards contraception, sterilization and abortion, the role of overcrowding in mental illness, and "psychiatric and social sequelae of unwantedness." On this last point he referred to Scandinavian studies which showed that unwanted children grew up "worse off in every respect" than children in a parallel control group, and added that he has seen comments by prison workers that most convicts started out as unwanted children, "rejected first by their parents and then by society." For a crime-ridden country like the United States, he added, this aspect alone should make such research eminently valuable.

Support of the need for reassessment of the role of psychiatry in abortion was sounded by Dr. H. L. P. Resnik, Chief, Center for Studies of Suicide Prevention, National Institute of Mental Health, and Byron J. Wittlin, third year medical student at the State University of New York at Buffalo, writing in a recent issue of *Mental Hygiene*. With most 'liberalized' laws including a provision permitting abortion if the mother's mental health is endangered by continued pregnancy, forcing psychiatry more and more into bearing the responsibility for legal abortions in this country, psychiatrists must in turn reevaluate the basis on which they find such mental health problems, they maintain.

Essentially, Dr. Resnik and Mr. Wittlin feel that 'endangering the mental health of the mother' is a meaningless term, and that psychiatrists should work to expose it. After all, they point out, there is good evidence that when a mother is depressed or anxious about carrying an unwanted pregnancy, her mental health is endangered. Proper preventive psychiatry, therefore, is abortion, if she asks for it. If psychiatrists follow this course, which does protect the mother's mental health, then "abortion will occur legally, under proper medical supervision, in accredited hospital surroundings, without inequality, with far less expense and with less guilt attached to the act," they say.

The authors recommend that requests for abortion on the mental health indication be granted when:

- there is risk of precipitating a psychosis or aggravating an existing one or exacerbating a latent psychosis;
- there is risk of postpartum depressive reaction;
- there is risk of aggravating severe existing neurosis;
- there is risk of infanticide, crippling abuse, neglect or abandonment;
- the mother is mentally retarded and unable to comprehend her condition and the attendant responsibilities, or
- there is likelihood that the mother would seek out an illegal abortion.

Since such past literature as exists on the psychological sequelae to abortion includes a wide range of conclusions based on scanty data, several recent studies have attempted to define more exactly how abortion affects a woman's mental state. The general conclusion of these studies, which have been based on detailed psychological tests and lengthy interviews, is that the mental health

of most women is improved by their abortion. Interviews and psychological tests conducted on 30 low-income women approved for abortions at Harbor General Hospital in Torrance, California, for example, showed higher levels of both subjective complaints and test-measured personality disturbance before the abortion than after, in all but the most disturbed women. According to Dr. Charles V. Ford and his associates, writing in the *Journal of the American Medical Association*, "therapeutic abortion alleviates to a significant degree the acute psychological distress associated with unwanted pregnancy."

The California team was especially struck by the fact that the more seriously disturbed women seemed to improve less following an abortion than did the relatively normal ones. The most disturbed, they found, might even incorporate the abortion into their mental illness and come out worse off than they were before. The only relatively normal women who did not improve in the course of the study were the small group who were refused an abortion and carried their pregnancies to term. These findings, Dr. Ford and his associates feel, tend to contradict the traditional attitude in abortion committees that seriously disturbed women are the better abortion candidates since more normal women should be expected to tolerate the pregnancy reasonably well.

Two encouraging sequelae of abortion in this low-income group were a greater use of effective contraception and, among a few of the women, an increased interest in the children they already had, according to the study.

Canadian Results Similar

Comparable results come out of a similar Canadian study, in which abortion candidates went through a battery of tests and interviews pre- and postabortion. Psychological responses were "rapid, positive and lasting," a University of Calgary team reported recently in the *American Journal of Obstetrics and Gynecology*. As in California, "continuing psychological problems were most obvious in the small group who were rejected."

While routine psychiatric consultation is generally deplored, for a few abortion candidates psychiatric consultation does indeed serve a genuine medical need. Dr. Ford, in another article written for *Obstetrics and Gynecology*, notes that "it is essential for psychotic women, for those with a history of psychosis and for those who have suicidal ideation which persists after the offer of an abortion." Dr. Ford recommends that when the family physician or gynecologist suspects serious psychological problems he should refer those particular patients for psychiatric consultation. He concludes, "The overwhelming majority of women who receive a therapeutic abortion suffer no major psychologic reaction . . . and may be competently managed by enlightened nonpsychiatrists."

One potential problem group, Dr. Alan J. Margolis and associates at the University of California at San Francisco reported recently, are pregnant teenagers. In the small group they studied as part of a larger abortion follow-up project, they found a great deal of ambivalence and guilt. Since, as they point out, great difficulties await both the teenager and her family if she carries the baby to term, especially careful counseling on the balance of risks involved should be provided these girls and their families by a team of physician, psychiatrist and social worker.

In this connection, the American Academy of Pediatrics recently issued a statement embodying guidelines to help pediatricians discharge with "compassionate and considerate understanding . . . [the] heavy responsibility" placed upon them in caring for adolescents considering abortion. The statement said, in part:

> Although the Academy prefers neither to sanction nor to forbid the use of abortion to terminate an unwanted pregnancy in the teenage girl, it does have the responsibility to insist that physicians considering this recourse provide for appropriate counseling and support for these girls and other involved persons, including the young fathers.
>
> . . . [T]he pediatrician must make certain that adequate information and sex counseling are available. . . . Contraceptive advice and prescription for the sexually active teenage girl should be accompanied by investigation and alteration of contributing issues wherever possible.
>
> Continuing long-term support directed toward facilitating personality development is an integral part of the care situation. Abortion must never be allowed to replace adequate preventive care or contraceptive measures. [For the teenager], abortion . . . is often replete with problems, ambivalent feelings, and guilt. The pregnant teenager is often alone, or feels alone, is frightened, frequently estranged from her family and, on occasion, emotionally disturbed. The physician . . . should make every attempt to have the girl involve her parents in making her decisions. . . .
>
> Often in these troubled situations, the physician entrusted with the care of an adolescent girl must and should serve as her advocate. All possible alternatives should be explored by the physician . . . with the adolescent girl, unencumbered by coercive, punitive, or prejudicial attitudes. . . . The physician-advocate must safeguard the physical and emotional welfare of the essentially defenseless . . . patient . . . and in so doing protect her rights of confidentiality and privacy.

There appears to be a consensus in the recent psychiatric literature on abortion that the appropriate role of the psychiatrist is as a consultant, in much the same way that any other medical specialist might be invited to offer his expertise when necessary.

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Teaching Tools

Family Planning Professionals' Guides

Four recent booklets produced by the International Planned Parenthood Federation should prove helpful to professionals and paraprofessionals involved in family planning programs. In one, *Family Planning for Midwives and Nurses*, the central role of this category of worker is highlighted, with special emphasis on the initiation of discussion of family planning with patients who may be too shy or uninformed to raise questions themselves. Not only are the various methods of birth control described in accurate, simple language, but what to tell the patient about each method is an unusual feature.

The importance of cervical and vaginal cytology as part of family planning is explained

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in *Cervical and Vaginal Cytology*. Essentially a 'how-to' discussion, the booklet would be of enormous help to those working in rural areas, remote from laboratories or hospitals where cytology is performed routinely by experts. In addition to explaining the cytology of the female genital tract, the pamphlet explains how to collect materials for smears, how to fix and stain smears and how to interpret them.

The third pamphlet, *Intrauterine Contraception*, discusses the various IUDs, insertion and removal techniques, timing of insertion, sterilization procedures, contraindications and side effects associated with the devices. It includes a table on net cumulative event rates and presents an interesting comment on cross-cultural applicability of data. There are clear black and white drawings of 23 IUDs as well as of an introducer and plunger, and diagrams of the uterine cavity showing insertion of an IUD and its final positioning.

The classification and techniques of abortion are detailed in simple straightforward language in the pamphlet, *Abortion*. Although providing instruction in curettage and vacuum aspiration, it is made quite clear that "it is not intended to stand by itself and can never replace practical instruction gained in the company of experienced doctors." The booklet concludes with a discussion of the importance of contraceptive counseling and service for all abortion patients.

Sources

These pamphlets, in English, Spanish and French, are published by and available from the International Planned Parenthood Federation, 18-20 Lower Regent Street, London, S.W. 1, England. Editor of the four manuals is R. L. Kleinman, M.B., Ch.B., D.(Obst.) R.C.O.G.:
"Abortion," 1971, $1.00.
"Cervical and Vaginal Cytology," 1971, $.75.
"Family Planning for Midwives and Nurses," 1971, $1.25.
"Intrauterine Contraception," 1972, $1.00.

Family Planning Job Opportunities

Family planning agencies are invited to send job opportunity statements for professional positions to:
National Center for Family Planning Services
HSMHA, DHEW
5600 Fishers Lane, Room 12A-33
Rockville, Maryland 20852
The National Center for Family Planning Services, HSMHA, does not necessarily support the agencies seeking to fill positions.

All openings listed below are with Equal Opportunity employers.

●

Position: Great Lakes Region Assistant Director
Agency: Great Lakes Regional Office, Field Department, Planned Parenthood-World Population
Location: Detroit, Mich.
Salary: $16,500
Job Description: Provide support to the Regional Director in program and affiliate matters, in coordination with the activities of the regional staff as a whole. As assigned by the Director, this may include staff support of the Regional Council of the Public Affairs Network, and of the other volunteers of the region, as well as the coordination of regional activities with those of the Field Department at the national level and other Planned Parenthood-World Population Departments. Act for the Regional Director in specifically delegated program areas.
Qualifications: Minimum of two and one-half years experience (preferably both rural and urban) with Planned Parenthood affiliates or other voluntary health agencies. Some experience with federal programs also valuable. Some planning, training and/or M.A. or M.S. desirable, but not required.
Contact: Terrence P. Tiffany, Great Lakes Regional Office, 234 State Street, Detroit, Mich. 48226

●

Position: Medical Director
Agency: Pima/Santa Cruz Committee for Economic Opportunity, Inc.
Location: Tucson, Ariz.
Salary: $30,000
Job Description: The physician will be responsible for establishing and staffing family planning, prenatal, postpartum, well-child and other clinics as the need arises. Clinics will be established at the Santa Cruz County Health Department and will serve residents of Nogales, Arizona, 60 miles south of Tucson, a border community of less than 9,000 persons. It is considered a medical scarcity area with one MD per 1,995 population as compared to one MD per 788 persons in Arizona. The County Health Department presently offers only medical services for immunization, tuberculosis control and VD screening. The position will be funded under an Office of Economic Opportunity Family Planning Demonstration grant from July 1, 1972 through March 31, 1974.
Qualifications: MD licensed to practice in Arizona. Experience in working with low-income persons and in community medicine are preferred. Ability to speak Spanish is important. Administrative background is desirable.
Contact: Barbara Altman, Planning and Program Development Director at the Committee for Economic Opportunity, Inc., 721 North Fourth Avenue, Tucson, Ariz. 85705

●

Position: Executive Director
Agency: Planned Parenthood Association of Northeast Texas
Location: Dallas, Tex.
Salary: open
Job Description: Carry out the affiliate program and implement the larger goals within the community. Work with the Board of Directors to build policy and programs and to set directions. Recruit, train and supervise agency staff and volunteer workers. Approximate budget, $600,000.
Qualifications: Family planning experience is essential. At least three years of management experience; excellent administrative skills essential.
Contact: Betty Synar, President, Planned Parenthood Association of Northeast Texas, 3620 Maple Avenue, Dallas, Tex. 75219

Credits

p.1: from Julius Schmid; p.3: Bonnie M. Freer; pp.4,10,12: Ken Heyman; p.6: David Amundsen; p.7: from Dr. Clifford R. Wheeless, Jr.; p.9: Bernard Cole; p.11: UPI.

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